No. 89-1048

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

FMC CORPORATION,

Petitioner,

v.

CYNTHIA ANN HOLLIDAY,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF THE CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND AS AN *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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THE INTEREST OF THE AMICUS CURIAE

The Central States, Southeast and Southwest Areas Health and Welfare Fund ("Fund") is a Taft-Hartley trust and an employee welfare benefit plan as described in Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1002(1).[1] *See Central States, Southeast and Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 561-562 (1985). The Fund self-funds all medical, hospital and disability benefits that it provides to its more than 500,000 participants and beneficiaries. These participants and beneficiaries reside in over thirty-four states of the United States.

Due to escalating medical care costs and limited income in the form of fixed employer contributions, the Trustees of the Fund have included cost-containment measures, such as subrogation and coordination of benefits provisions, in the plan pursuant to their fiduciary duties under ERISA to manage plan assets prudently and in the best interest of all participants and beneficiaries. *See* 29 U.S.C. §1104(a)(1)(B). The Fund is significantly and adversely affected by the ruling in this case by the United States Court of Appeals for the Third Circuit because the Fund does provide benefits to participants and beneficiaries who reside in Pennsylvania. Due to the Third Circuit's opinion in this case, the Fund probably will not be able to enforce its subrogation provision in Pennsylvania and thus will be deprived of an important cost-containment meas-

[1] Both the petitioner, FMC Corporation, and the respondent, Cynthia Ann Holliday, gave the Fund consent to file this *amicus curiae* brief, and copies of their attorneys' letters confirming this consent have been sent with this brief to the Clerk of the United States Supreme Court.

ure. Moreover, the Fund will have to adopt different administrative procedures to comply with this Pennsylvania insurance law, thereby causing the Fund to incur another financial cost and administrative burden.

The Fund is also adversely affected by the increasing disregard of the scope of ERISA preemption as demonstrated by the decision in this case and the decision of the United States Court of Appeals for the Sixth Circuit in the case of *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988). Both circuits have advanced equally vague tests for ERISA preemption which subordinate Congress' objective in including a broad preemption provision in ERISA, which is uniform, federal regulation of employee benefit plans, to state regulation of insurance. If this precedent is not corrected by this Court, the Fund, like thousands of other multi-state employee welfare benefit plans, will have to comply with conflicting and inconsistent state laws, many of which will require such plans to duplicate benefits or assume the financial burden of specific risk insurance coverage from specific risk insurers. These plans will also be forced to engage in substantial and widespread litigation due to the vagueness of these preemption tests.

Such precedents will encourage other states to adopt laws regulating employee benefit plans. The resulting patchwork scheme of federal and state regulation of self-funded employee welfare benefit plans will force these plans to reduce substantially their benefit levels. Accordingly, the Fund urges this Court to reverse the Third Circuit and to hold that ERISA preempts all state laws that relate to self-funded employee welfare benefit plans, including state insurance laws.

SUMMARY OF THE ARGUMENT

The Fund urges this Court to reverse the holding of the United States Court of Appeals for the Third Circuit in this case for several reasons. First, the Third Circuit's interpretation of the deemer clause of Section 514 of ERISA directly conflicts with the plain meaning and legislative history of Section 514 and with several of this Court's decisions. By advancing a new test for ERISA pre-emption which states that the deemer clause allows preemption of state insurance law only where the state law conflicts with a "core ERISA concern," the Third Circuit is undermining the clear and expressed purpose and intent of Congress in including a broad preemption provision in ERISA which was to prevent patchwork regulation of self-funded employee benefit plans by the states. Moreover, the Third Circuit's holding directly conflicts with the decisions of this Court in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). Contrary to the Third Circuit's ruling, this Court in *Shaw* held that ERISA preemption is not limited to state laws that deal only with the subject matters covered by ERISA. 463 U.S. at 98. Moreover, the Third Circuit's holding violates the distinction mandated by Congress and recognized by this Court in the *Metropolitan Life* case, wherein this Court stated that insured employee benefit plans are subject to indirect state regulation while self-funded plans are not. 471 U.S. at 747.

This decision should also be reversed because the decision of the Third Circuit further splits the United States Courts of Appeal on the issue of the scope of ERISA preemption for self-funded employee benefit plans. Both

the Third Circuit in this case and the Sixth Circuit in the case of *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988), have advanced different but equally vague and insupportable tests for ERISA preemption. The Third and Sixth Circuits' restrictive interpretations of Section 514 conflict with the interpretations given by the Eighth, Seventh, Ninth, Fourth and Fifth Circuits.

The Third Circuit's decision also creates serious public policy problems. It effectively prohibits self-funded employee benefit plans from enforcing plan cost-containment measures that are critical to such plans. As a result of escalating medical care costs and the limited financial resources of such plans, many such plans have adopted subrogation and coordination of benefits provisions as cost-containment measures. If such plans are precluded from utilizing these cost-containment measures, comparable reductions in benefit levels will, at a minimum, have to occur.

Moreover, the vague tests advanced by the Third and Sixth Circuits for determining whether ERISA preempts a particular state law have caused and will continue to cause extensive and expensive litigation which employee benefit plans can little afford. If the precedents set by Third and Sixth Circuits are upheld by this Court, multi-state employee benefit plans will incur the substantial and potentially crippling administrative and financial costs of having to adopt separate plans and administrative procedures for each state in which their participants and beneficiaries reside. Therefore, the Fund recommends that this Court reverse the decision of the Third Circuit and uphold broad preemption under ERISA of state law relating to self-funded employee benefit plans.

ARGUMENT

I.

THE PREEMPTION TEST ADVANCED BY THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT SEVERELY LIMITS THE SCOPE OF ERISA PREEMPTION IN VIOLATION OF THE PLAIN MEANING AND LEGISLATIVE HISTORY OF SECTION 514 OF ERISA AND THIS COURT'S DECISIONS.

The Third Circuit's decision in the instant case directly conflicts with the plain meaning and legislative history of Section 514 of ERISA and with several of this Court's decisions which construe Section 514 of ERISA. In the instant case, the Third Circuit presented a new test for ERISA preemption, allowing preemption of a state insurance law only where the state law conflicts with a "core ERISA concern." *FMC Corp. v. Holliday*, 885 F.2d 79, 86, 89-90, *reh'g denied*, ____ F.2d ____ (3rd Cir. 1989), *cert. granted*, ____ U.S. ____, 110 S.Ct. 1109 (1990). To justify adoption of this "core conflict test," which subordinates Congress' goal to establish uniform, comprehensive federal regulation of employee benefit plans to the states' power to regulate insurance, the Third Circuit advances an insupportable interpretation of the deemer clause in Section 514, selectively cites legislative history out of context and criticizes a prior ruling by this Court. As to the distinction drawn between preemption as applied to self-funded employee benefit plans and insured employee benefit plans articulated by this Court in the *Metropolitan Life* case, the Third Circuit states that it lacks statutory and legislative history foundation. *Id.* at 86-89. The Third Circuit's decision also constitutes a direct conflict with this Court's holding that ERISA preemption is not limited to state laws that deal

with the subject matters covered by ERISA. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 98.

In construing the meaning of a statute, the starting point of such an analysis is the language of the statute, and unless an ambiguity in the language exists, this analysis should end without resorting to an analysis of the legislative history underlying the statute. *See United States v. Ron Pair Enterprises, Inc.*, 489 U.S. ____, 109 S.Ct. 1026, 1030, 103 L.Ed.2d 290 (1989). In the instant case, the Third Circuit does not identify any ambiguity in the deemer clause. Instead, it attempts to justify its selective review and strained analysis of the legislative history underlying the deemer clause by stating that the deemer clause's "scope is unclear." 885 F.2d at 84. The Third Circuit then concludes that ". . . the deemer clause guards against any insurance regulation that infringes on such ERISA areas as reporting, disclosure and non-forfeitability." *Id.*

The Third Circuit's analysis and conclusion are erroneous for several reasons. First, there is no ambiguity in the deemer clause. This Court has held that the plain meaning of the deemer clause is unambiguous: "The deemer clause makes clear that a state law that 'purport[s] to regulate insurance' cannot deem an employee benefit plan to be an insurance company." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987). Thus, the deemer clause is the specified exception to the savings clause, which preserves state insurance and other laws from ERISA preemption, and the deemer clause prohibits employee benefit plans from being regulated by ". . . any law of any State purporting to regulate insurance companies, insurance contracts. . . ." 29 U.S.C. §1144(b)(2)(B). *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 733 (1985). Moreover, this Court has emphasized that, in construing

Section 514 of ERISA, the plain language must be enforced unless there is a good reason to believe Congress intended a more restrictive meaning to apply. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 97.

The Third Circuit's analysis of the deemer clause also fails due to its highly selective and biased review of the legislative history underlying Section 514 of ERISA. In examining the legislative history, the Third Circuit maintains that preemption under the deemer clause is basically limited to state laws that constitute ". . . back-door attempts by states to regulate core ERISA concerns in the guise of insurance regulation." 885 F.2d at 86, *cited in, Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85, 91-94 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988). To support this argument, the Third Circuit selectively quotes comments of ERISA legislative sponsors which relate only to their concern with state laws being "hastily contrived" to regulate ERISA plans. However, the very quotations utilized by the Third Circuit serve to underscore Congress' primary concern in including a broad preemption provision in ERISA, which was that employee benefit plans be subject to uniform federal regulation. The Senator Javits quotation, that ERISA preemption extended to " '[s]tate laws hastily *contrived* to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme,' " clearly expresses his concern with the states' passing laws after ERISA's enactment to regulate areas of plan administration and operation not specifically governed by ERISA. 885 F.2d at 87. Senator Williams' statement also stressed Congress' concern that state professional regulations ". . . should not be able to prevent unions and employers from maintaining the types of employee benefit programs which Congress has authorized." *Id.*

Uniform federal regulation of employee welfare and pension benefit plans was one of the fundamental and overriding purposes of Congress in enacting ERISA. So as to remove any doubt concerning the purposes that ERISA was to serve, Congress set forth its findings and declaration of policy in Section 2 of ERISA, which, in part, provides:

> The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations;
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> * * * * *

29 U.S.C. §1001(a).

Moreover, ERISA's legislative sponsors stressed the importance of uniform federal regulation of employee benefit plans. In quoting Senator Williams, the Third Circuit ignores his explanation of the scope of ERISA preemption:

> It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

Shaw v. Delta Air Lines, Inc., 463 U.S. at 99, *quoting* 120 Cong. Rec. 29933.

The Third Circuit also selectively cites Senator Javits' remarks, which continued after the statement quoted by the Third Circuit: "Although the desirability of further regulation—at either the State or Federal level—undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs." *Id.* at 99-100 n.20. As to the task force report denigrated by the Third Circuit, it was Senator Javits who explained that the members of the conference responsible for the final draft of ERISA had assigned the Congressional Pension Task Force with the responsibility of studying and evaluating ERISA preemption to determine what modifications in preemption policy would be necessary. *Id.* Another ERISA sponsor, Representative Dent, who was not quoted by the Third Circuit, also stressed the breadth of ERISA preemption:

> Finally, I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.

Id. at 99.

In examining the proposed house and senate bills and the conference bill ultimately passed by Congress, the Third Circuit does not grasp the significance of Congress' rejection of the bills which would have preempted only state laws affecting subjects specifically addressed in ERISA. By attempting to construe the word "purporting" in the deemer clause as the basis for limiting preemption to subject areas specifically regulated by ERISA, the

Third Circuit ignores the touchstone of Congress' expressed concern in incorporating a broad preemption provision in ERISA, *i.e.*, the establishment of uniform federal regulation of employee benefit plans. Moreover, its interpretation of the deemer clause would effectively incorporate the very language rejected by the Congress.

Based upon a thorough examination of the legislative history underlying Section 514 of ERISA, this Court has repeatedly held that ERISA preemption cannot be limited to only those state laws which regulate the matters covered by ERISA, including reporting, disclosure and fiduciary responsibility. 463 U.S. at 98. On the contrary, this Court has held that Section 514 was intended ". . . to displace all state laws that fall within its sphere, even including state laws that are consistent with ERISA's substantive requirements." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 739. As this Court has repeatedly explained, Congress considered and rejected bills which allowed preemption of only subject matters expressly governed by ERISA and which did not include a deemer clause reserving regulation of ERISA plans to the federal government. 463 U.S. at 98; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 46. These bills were rejected not only because they would have required ERISA plans to comply with multiple and potentially conflicting state laws, but also because they raise the possibility of "endless litigation" on issues of whether state regulation impinged upon federal regulation. 463 U.S. at 99 n.20. Moreover, after a period of monitoring by the Congressional Pension Task Force and hearings by a House Subcommittee, a report evaluating ERISA's preemption provisions was issued, and it stated that "the Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded." *Id.* at 100 n.20, *quoting* H.R. Rep. No. 94-1785, p. 47 (1977).

Despite this clear authority supporting the wide scope of ERISA preemption, the Third Circuit further contends that any interpretation of the deemer clause other than that it prohibits insurance regulation of the "central aspects of ERISA" would render the savings clause meaningless or read in distinctions that are not supported by the statute. 885 F.2d at 88. Although the Third Circuit does not explain how any other interpretation of the deemer clause would "swallow" the savings clause, it criticizes this Court's interpretation of the savings and deemer clauses in the *Metropolitan Life* case, wherein this Court stated that insured plans are subject to indirect state regulation while self-funded employee benefit plans are not. *Id.* at 89. The Third Circuit implies that this Court erroneously created this distinction between self-funded and insured plans without reliance upon statutory language or legislative history, but instead based this distinction upon the "vague language in Congress' *post hoc* study." *Id.* at 89.

Again, the Third Circuit ignores the statutory language and legislative history of Section 514 of ERISA. The deemer clause prevents an employee benefit plan from being deemed an insurance company or other insurer or as being engaged in the business of insurance ". . . for purposes of any law of any State purporting to regulate insurance companies, insurance contracts. . . ." 29 U.S.C. §1144(b)(2)(B). However, the deemer clause does not preempt state laws regulating insurance contracts purchased by an employee benefit plan. The regulation of the content of insurance contracts is not subject to preemption due to the plain meaning of the savings clause. Thus, if an employee benefit plan chooses to self-fund its benefits, it cannot be deemed an insurance company which companies must under the laws of most, if not all, states submit their benefit plan provisions concerning eligibility,

benefit levels and terms and conditions for receiving benefits to the state department of insurance for review and approval as to their compliance with the state insurance code and other regulations. *See Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. at 727-728. On the other hand, those plans which decide to purchase insurance coverage for their members from insurance companies must comply with the state law limitations placed on those insurance contracts. This indirect regulation of insured plans is thus expressly sanctioned by Congress. Moreover, the fact that plans may choose to self-fund benefits, and thus be entitled to adopt benefit rules without regard to state law, or to purchase insurance policies subject to state law restrictions comports with both the statutory provisions of ERISA's entrusting plan fiduciaries with exclusive authority to manage and control plan assets and with the legislative history which establishes that plan fiduciaries have broad discretion in determining how the plan is to be administered. *See* 29 U.S.C. §§1102(a)(1), 1103(a).

The Third Circuit takes an alternative position that its proposed test concerning the application of the deemer clause would not eradicate the distinction drawn by this Court between insured and self-funded employee benefit plans. 885 F.2d at 89. The Third Circuit explains that ". . . under *Metropolitan Life* insured plans would *per se* survive the deemer clause, while self-insured plans would merely be considered on a case-by-case basis as to whether the state regulation involved affects a central concern of ERISA." *Id.*

The Third Circuit's contention that its proposed test is actually in compliance with the Court's guidelines in *Metropolitan Life* lacks merit. The Third Circuit does not identify any statutory, legislative history or Supreme

Court case law authority for interpreting the deemer clause so as to limit preemption to those state laws which affect a "central concern" of ERISA. Furthermore, the Third Circuit does not define what constitutes a "central concern" of ERISA. Acknowledging the vagueness of its test, the Third Circuit admits that ERISA preemption of state law as applied to self-funded employee benefit plans will have to be decided on a case-by-case basis. This result was exactly what Congress expressly sought to preclude by adopting a broad preemption provision.

Because the Third Circuit rejects uniformity of regulation of employee benefit plans as a "central concern" of ERISA, it is apparent that the Third Circuit is suggesting a highly restrictive definition of "central concern" of ERISA. Thus under the Third Circuit's test, multi-state plans which, as this Court has recognized, already have the task of coordinating complex administrative activities will also have to endure the considerable inefficiencies, administrative burdens and financial costs of complying with a patchwork scheme of regulation. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. at 11. Such a result cannot be allowed to stand under the plain meaning and legislative history of Section 514 and the decisions of this Court.

II.

IF THE DECISION OF THE THIRD CIRCUIT IS NOT REVERSED AND THE SCOPE OF ERISA PREEMPTION MAINTAINED AT ITS BROAD LEVEL, SIGNIFICANT AND ADVERSE PUBLIC POLICY PROBLEMS WILL RESULT.

The conflicts among the circuits concerning the issue of the scope of ERISA preemption as to self-funded employee benefit plans is thoroughly discussed by FMC Corporation in its brief. To avoid repetition, the Central

States, Southeast and Southwest Areas Health and Welfare Fund ("Fund") will concentrate on the adverse public policy problems that will result unless this split among the circuits is resolved by reversing the Third Circuit and allowing broad preemption of state laws relating to employee benefit plans.

The problem of rising medical care costs for self-funded employee benefit plans cannot be overstated. For every year since 1965, inflation in medical care prices has been higher than the general rate of inflation for the economy on a whole.[2] In 1987, the price of health care in this country exceeded $500 billion, increasing 9.8 percent from 1986.[3] In 1988, total health care expenditures rose 10.2 percent from 1987 to an estimated $558.7 billion or about $2,200.00 per capita.[4] Total health care expenditures for 1989 are expected to rise to approximately $618.4 billion.[5] If health care trends continue, medical care costs could triple to $1.5 trillion by the year 2000.[6]

In 1988, employers with insured programs experienced an average increase in health plan costs of 13.7 percent; whereas, self-funded plans experienced an average increase of 24.8 percent in health plan costs for 1988.[7] In one survey of 2,000 employers who either purchased insurance coverage or self-funded health benefits, total health care costs equaled 37.2 percent of those employers' profits.[8]

As a result of these substantial and escalating costs of providing medical care, employee benefit plans throughout the country have had to reduce benefits, institute cost-containment measures, establish cost-management programs or a combination of the above. In compliance with their fiduciary duties under ERISA to manage plan assets prudently and in the best interest of all participants and beneficiaries, the Trustees of the Fund have included cost-containment measures in the plan, including subrogation and coordination of benefits provisions. *See* 29 U.S.C. §1104(a)(1)(B). The Trustees determined that these cost-containment measures are necessary to preserve plan assets for the payment of current and future medical benefits and to eliminate duplication of benefits with other insurance or plan coverages. The Fund's Trustees included these subrogation and coordination provisions as part of the plan terms in compliance with their fiduciary duties to manage the plan assets ". . . solely in the interest of the participants and beneficiaries . . ." and, in managing these assets, to exercise ". . . the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." 29 U.S.C. §1104(a)(1)(B).

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[2] Sharkey & Buckle, *The Medicare Prospective Payment System: Impact On The Frail Elderly and An Alternative Reimbursement Formula*, 3 Notre Dame J. of L., Ethics & Pub. Pol'y 227, 228 (1988).

[3] Letsch, Levit & Waldo, *National Health Expenditures, 1987*, 10 Health Care Fin. Rev. 109 (Winter 1988).

[4] Francis, *U.S. Industrial Outlook 1989: Health Services*, Med. Benefits, Feb. 15, 1989, at 1.

[5] *Id.* at 2.

[6] *Costs Will Rise into the 1990s, Pushing Up Corporations' Benefits Costs*, 16 Pens. Rep. (BNA) 1979 (November 20, 1989).

[7] A. Foster Higgins & Co., *Health Care Benefits Survey, 1988*, Med. Benefits, Feb. 28, 1989, at 1. *See also, Average Costs Rose 18.6 Percent Under Employer Plans, Survey Finds*, 16 Pens. Rep. (BNA) 250 (Feb. 13, 1989). This survey covered 1,600 employers and 10 million employees and dependents.

[8] DiBlase, *Group Health Bills Equal A Third of Profits*, Bus. Ins., May 29, 1989, at 1.

Multiemployer benefit plans, such as the Fund, are particularly affected by substantial increases in medical care costs because their income is primarily, if not solely, from employer contributions. The amount of each employer's contribution is fixed by collective bargaining agreements negotiated by the union and employers every three to five years. Depending upon how much of the collectively bargained moneys are allocated to wages, pension benefits and health benefits, there may not be sufficient funds to maintain health benefit levels. If the employers' contributions are not sufficient to fund plan benefits, the trustees of such plans have limited choices, namely to reduce benefit levels and/or to institute cost-containment measures.

Although most cost-containment measures and benefit reductions involve a transfer of costs to the participants and beneficiaries or a restriction in the type or length of medical care, two cost-containment measures, subrogation and coordination of benefits, do not. On the contrary, subrogation and coordination of benefits provisions prevent the duplication of benefits by the plan where other coverage exists and covers the particular injury or illness. Subrogation and coordination provisions also ensure that primary responsibility for providing benefits for specific risk injuries is not transferred from specific risk insurers, such as motor vehicle insurers, to employee benefit plans.

The Fund's Plan Document provides for subrogation against any person or entity responsible for providing a recovery to a Fund participant or beneficiary for injuries sustained as a result of an accident or illness. The Fund's coordination provision provides that where no-fault or personal injury protection ("PIP") motor vehicle insurance coverage exists, the no-fault or PIP coverage shall be primarily responsible for providing benefits to a mutually covered beneficiary who has sustained injuries as a result

of a motor vehicle accident and the Fund shall provide excess coverage. These subrogation and coordination provisions provide substantial cost-savings to the Fund, allowing it to cover rising medical costs without having to enact comparable benefit cuts or restrictions.

The application of state laws to prohibit the Fund from enforcing its subrogation and coordination provisions would deprive the Fund of very valuable and necessary cost-containment measures. If this were to occur, the Trustees would be limited primarily to changes in the benefit plan design that transfer the rising costs of medical care to the Fund's participants and beneficiaries, *e.g.*, lower percentage of coverage and higher deductibles, or that restrict their medical care options.

Currently, there are two circuit court decisions which limit the scope of ERISA preemption as applied to employee welfare benefit plans. In addition to the Third Circuit's decision, the United States Court of Appeals for the Sixth Circuit in the case of *Northern Group Services, Inc. v. Auto Owners Ins., Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988), also propounded a new test subordinating the Congressional goal of uniform federal regulation of employee benefit plans to the state's interest in regulating insurance. In *Northern Group*, the Sixth Circuit held that Section 500.3109a of the Michigan No-Fault Insurance Act, which authorizes motor vehicle insurance companies and their insureds to subordinate motor vehicle no-fault benefits to benefits provided by "other health and accident coverage," was not preempted by ERISA because of the priority of the state's power to regulate insurance. 833 F.2d at 94-95. To justify this holding, the Sixth Circuit advanced a new test for ERISA preemption, requiring that if a self-funded employee benefit plan is to avoid state regulation, it must first demon-

strate a federal interest in national uniformity *independent of and beyond* the requirements of Section 514 of ERISA, and that this specific federal interest must then ". . . outweigh the McCarran-Ferguson interest in state regulation of insurance." *Id.* at 95.

State laws such as Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law and Section 500.3109a of the Michigan No-Fault Insurance Act effectively usurp the Trustees' exclusive authority and responsibility under ERISA to control and manage plan assets in the best interest of all participants and beneficiaries. *See* 29 U.S.C. §1102(a)(1) (the plan must be administered pursuant to a written instrument and named plan fiduciaries have authority ". . . to control and manage the operation and administration of the plan."); 29 U.S.C. §1103(a) (". . . the trustee or trustees shall have exclusive authority and discretion to manage and control the assets of the plan . . ." except for certain circumstances not applicable to this case); 29 U.S.C. §1104(a)(1)(D) (plan fiduciaries are required to perform their duties solely in the interest of all participants and beneficiaries in accordance with the provisions of the plan document).

There are a substantial number of state laws either prohibiting or restricting subrogation and coordination in the contexts where the Fund utilizes these cost-containment measures. *See, e.g., Baxter v. Lynn*, 886 F.2d 182, 185, *reh'g denied*, ____ F.2d ____ (8th Cir. 1989) (Missouri common law limitation on subrogation); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986) (Arizona anti-subrogation law); *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988) (Michigan statute making all health coverages primarily responsible and making no-fault motor vehicle coverages secondarily responsible

for benefits concerning injuries sustained in motor vehicle accidents); *Hunt v. Sherman*, 345 N.W.2d 750 (Minn. 1984) (Minnesota common law restriction on subrogation). If the decision in this case is allowed to stand, there is little doubt that states with such laws will increasingly attempt to enforce them and other states will consider adopting similar laws.

These state laws effectively mandate that employee welfare benefit plans provide specific risk insurance coverage, such as coverage for injuries incurred in motor vehicle accidents, even though such coverage is available from the specific risk insurers. Coordination laws, such as the Michigan statute at issue in *Northern Group*, authorize motor vehicle no-fault insurers and their insureds to dictate when employee benefit plans must pay benefits and what amount of benefits they must pay in contravention of the plans' terms as set forth in their plan documents. Through such laws, state legislators, who are subject to extensive lobbying campaigns by the insurance industry, can lower specific risk insurance premiums and transfer the cost of insuring such specific risks from specific risk insurers, such as no-fault motor vehicle insurers, to employee benefit plans. Thus, the Fund's assets will be used to subsidize the specific risk insurance coverage of participants and beneficiaries who reside in states with such laws. This results in a tremendous windfall for these specific risk insurers, which are generally profit-based companies, and an equally tremendous drain on self-funded employee benefit plans, which are non-profit entities. Moreover, assuming for purposes of argument that a plan could afford such a subsidy, which assumption is extremely unlikely, plan assets would not be uniformly used in the best interest of all participants and beneficiaries because the contributions made to the plan on behalf of

participants and beneficiaries in states without such laws would be used to subsidize the lower specific risk insurance premiums of those residing in states with such laws. Thus, the end result of these state laws is that employee benefit plans are forced to either duplicate benefits or to provide benefits in lieu of the specific risk insurer.

The proverbial floodgates of litigation, which have already been opened by the vague and differing preemption tests adopted by the Third and Sixth Circuits, will be pushed further open.[9] Unless this Court refuses to adopt the vague tests advanced by the Third and Sixth Circuits, multi-state employee benefit plans, which are struggling to meet increasing medical costs, will have to expend considerable plan assets on expensive litigation in states throughout the nation. Moreover, these plans cannot avoid this litigation because, *inter alia*, they cannot afford to eliminate these cost-containment measures and they cannot afford to administer a different plan in each

[9] As a result of the *Northern Group* decision, considerable litigation has ensued, and the cases listed below represent a small fraction of the cases filed concerning the application of the Michigan No-Fault Insurance Act to self-funded employee benefit plans: *Auto Club Ins. Ass'n v. Frederick & Herrud, Inc.*, 433 Mich. 900 (1989), *petition for cert. filed, Thorn Apple Valley, Inc. v. Auto Club Ins. Ass'n*, ___ U.S.L.W. ___ (U.S. Dec. 29, 1989) (No. 89-1125); *Central States, Southeast and Southwest Areas Health and Welfare Fund v. Hawkeye-Security Ins. Co.*, ___ U.S. ___, 109 S.Ct. 783 (1989); *Winstead v. Indiana Ins. Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. denied*, ___ U.S. ___, 109 S.Ct. 839 (1989); *Liberty Mutual Ins. Co. v. Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384, *reh'g denied*, ___ F.2d ___ (6th Cir. 1989).

In fact, the Sixth Circuit has recently issued another decision in the *Northern Group* case which will undoubtedly cause another massive wave of litigation. In its most recent decision, the Sixth Circuit has ruled that, while it determined that ERISA did not preempt Section 500.3109a of the Michigan No-Fault Insurance Act, it did not decide the issue of whether a self-funded employee benefit plan comes within the scope of Section 500.3109a. (The slip opinion issued by the Sixth Circuit is reprinted in the Appendix, p. 1a, *infra*.)

state in which they operate. Thus, the nightmare of patchwork regulation of employee benefit plans by the states, which Congress intended to avoid by enacting Section 514 of ERISA, is becoming a reality. Accordingly, the Fund urges this Court to reverse the decision of the Third Circuit in this case and follow the precedent clearly established by this Court in requiring broad preemption of state law under Section 514 of ERISA.

CONCLUSION

For the reasons discussed herein, this Court should reverse the decision of the United States Court of Appeals for the Third Circuit in this case and hold that Section 514 of ERISA preempts Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law.

Respectfully submitted,

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April 20, 1990

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APPENDIX

RECOMMENDED FOR FULL TEXT PUBLICATION
See Sixth Circuit Rule 24

No. 89-1053
UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

NORTHERN GROUP SERVICES, INC.; MASCO INDUSTRIES, INC., Benefit Plan for Hourly Employees of Forming Technology; MASCO INDUSTRIES, INC., Employees' Benefit Plan for Salaried Employees; MASCO INDUSTRIES, INC., Self-Funded Employee Benefit Plans; HIGHLAND APPLIANCE COMPANIES, Medical Benefit Plan,

Plaintiffs-Appellants,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY; AUTO OWNERS INSURANCE COMPANY; AUTO CLUB INSURANCE ASSOCIATION; FARMERS INSURANCE EXCHANGE; CITIZENS INSURANCE COMPANY OF AMERICA; MICHIGAN INSURANCE COMPANY; ALLSTATE INSURANCE COMPANY, jointly and severally,

Defendants-Appellees.

On Appeal from the United States District Court
for the Eastern District of Michigan

Decided and Filed March 21, 1990

Before: MERRITT, Chief Judge; MARTIN, Circuit Judge; and BROWN, Senior Circuit Judge.

MERRITT, Chief Judge. In a previous appeal in this action, our Court published on November 13, 1987, an opinion, *Northern Group Servs., Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir., 1987), *cert. denied*, 108 S.Ct. 1754 (1988), holding that the three preemption provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1144(a), 1144(b)(2)(A) and 1144(b)(2)(B), when read together, do not preempt § 3109a of the Michigan Insurance Code, M.C.L.A. § 500.3109a, insofar as it establishes coordination of benefit rules between automobile insurance and "health and accident coverage." The appeal in the previous case was from a district court ruling that the federal statute preempted the state statute, occupying the field of state coordination of benefit rules. We reversed that ruling and remanded the case to the District Court for further proceedings. The District Court then held on remand that this Court's previous opinion had interpreted § 3109a to apply to self-funded or self-insured ERISA benefit plans as well as insured plans *as a matter of state law*: "The Court concludes that the Sixth Circuit has ruled that § 3109a of the Michigan Insurance Code applies to plaintiff-employee benefit plans *as a matter of state law. . . .*" J.A. at 23 (emphasis added).

This ruling by the District Court was in error. We ruled only on the federal claim of preemption, the federal issue then before us, and did not attempt to rule on any pendent state claim requiring an explication of state law. We did not consider or rule, for example, on the question whether uninsured ERISA plans constitute "health and accident coverage" and thus whether § 3109a—as a matter of state law—applied to self-insured ERISA plans. For purposes of deciding the federal preemption question, and that question only, we merely assumed, without deciding,

that the coordination rules of § 3109a applied to both insured and uninsured ERISA plans. We referred to the fact that Michigan had "developed a substantial and complex body of common law and statutory principles to resolve questions of priority that arise when multiple coverage produces conflicts of the type presented in this case." *Northern Group Servs.*, 833 F.2d at 94. We did not attempt to precisely define those state law rules as they apply to various forms of coverage or ERISA plan benefits.

It was unnecessary for us to interpret § 3109a in any detail because in our previous case we only had to decide whether the preemption provisions of ERISA, *e.g.*, § 1144(a) (ERISA "shall supersede . . . State laws insofar as they . . . *relate to* any employee benefit plan") (emphasis added) and § 1144(b)(2)(B) (a provision saving from preemption "any law . . . purporting to regulate insurance"), should be interpreted to occupy the field of state coordination of insurance benefit rules, not whether a specific, isolated state coordination rule conflicts with a specific provision in an ERISA plan. For background concerning the various federal preemption principles, including "occupation of the field" preemption, see generally *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747-48 (1985); *Jones v. Truck Drivers Local Union No. 299*, 838 F.2d 856, 868-75 (6th Cir. 1988); Field, *Sources of Law: The Scope of Federal Common Law*, 99 Harv.L.Rev. 88-1 (1986).

Our previous opinion states in the first sentence that the question presented was whether ERISA preempts Michigan law "*to the extent* that the Michigan law allows policy provisions [on coordination of insurance benefits] which conflict with ERISA plans." *Northern Group Servs.*, 833 F.2d at 86 (emphasis added). We then explored the legislative history of the ERISA preemption provisions.

We did not explore the legislative history of the Michigan law or make any attempt to analyze which types of insurance or employee benefits fall under § 3109a.

The District Court judgment holding that our previous decision made a conclusive interpretation of § 3109a of the Michigan Code as a matter of state law is, therefore, in error. Its ruling that we concluded that § 3109a applied to self-insured ERISA plans is reversed. The case is remanded to the District Court.

The District Court on remand should treat the state law issues concerning the application of § 3109a of the Michigan Insurance Code as pendent state claims. It should exercise its discretion to retain and decide those pendent state issues under the principles established in *United Mine Workers v. Gibbs*, 383 U.S. 715, 726-27 (1966); *Gaff v. Federal Deposit Ins. Corp.*, 814 F.2d 311, 319 (6th Cir. 1987); *Beuth v. Brit Airlines, Inc.*, 749 F.2d 1235, 1240-41 (7th Cir. 1984), and other similar cases creating and applying standards to guide district courts in exercising jurisdiction over pendent state claims after the federal issue in the case has been decided.

Accordingly, the judgment of the District Court is reversed and the case remanded for disposition in accordance with this Court's instructions.